DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF

STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:	2. STATE
04-013	CO

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07/01/2004

5. TYPE OF PLAN MATERIAL *(Check one)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS A NEW PLAN x AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 C.F.R. 447.253

7. FEDERAL BUDGET IMPACT:
a. FFY__2004_____ -$292,675
b. FFY__2005_____ -$878,027

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19A page 3, 4 and 4a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If applicable)*:

Attachment 4.19A page 3 and 4

10. SUBJECT OF AMENDMENT:

Inpatient hospital rates.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐X OTHER AS SPECIFIED

Governor's letter dated July 1, 2003

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Vivianne M. Chaumont

13. TYPED NAME:

Vivianne M. Chaumont

14. TITLE:

Director, Medical Assistance Office

15: DATE SUBMITTED:

September 17, 2004

16. RETURN TO:

Colorado Department of Health Care Policy and Financing
1570 Grant
Denver, Colorado 80203

Attn: Trish Bohm

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 17, 2004

18. DATE APPROVED:
DEC - 8 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL - 1 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Carmen Keller

22. TITLE:
DCM (Deputy Director-Cmso)

23. REMARKS:

POSTMARK: Handcarried September 17, 2004

FORM HCFA-179 *(07-92)* *Instructions on Back*

7. Budget Neutrality: Budget Neutrality for PPS Hospitals is defined as no change in the summation of estimated payments to the PPS Hospital providers between State Fiscal Year 2003 and the State Fiscal Year for which the rates are being calculated. The estimated hospital specific payments are calculated by using hospital specific expected discharges, multiplied by the hospital specific average Medicaid case mix, multiplied by the Medicaid base rate. Effective July 1, 2004 Budget Neutrality is defined as a one percent decrease in the summation of estimated payments to the PPS Hospital providers between State Fiscal Year 2003 and the State Fiscal Year for which the rates are being calculated.

8. Medicaid Base Rate or Base Rate: An estimated cost per Medicaid discharge.

   For PPS Hospitals, excluding Rehabilitation and Specialty-Acute Hospitals, the hospital specific Medicaid base rate is derived from the hospital specific Medicare base rate minus any Disproportionate Share Hospital factors. The hospital specific Medicaid base rate will be calculated by modifying the Medicare base rate by a set percentage equally to all PPS Hospitals, excluding Rehabilitation and Specialty-Acute Hospitals. This percentage will be determined to maintain Budget Neutrality for all PPS Hospitals, including Rehabilitation and Specialty-Acute Hospitals.

   For Critical Access Hospitals, as defined by Medicare, and for those hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the Medicaid base rate used will be the average Medicaid base rate of their respective peer group, excluding the Critical Access Hospitals and those hospitals with less than twenty Medicaid discharges in the previous fiscal year.

   Medicaid hospital specific cost add-ons are added to the adjusted Medicare base rate to determine the Medicaid base rate. The Medicaid specific add-ons are calculated from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 of each fiscal year. Ten percent of the Medicaid cost add-ons will be applied to determine the Medicaid base rate. The hospital specific Medicaid cost add-ons will be an estimate of the cost per discharge for Nursery, Neo-Natal Intensive Care Units, and Graduate Medical Education. The estimated cost per discharge amount for Nursery and Neo-Natal Intensive Care Units will be calculated by multiplying the Medicare hospital specific base rate, without DSH, by the ratio of Medicaid Nursery or Neo-Natal costs to total Nursery or Neo-Natal costs respectively. A cost per discharge amount for Graduate Medical Education will be obtained directly from the most recently audited Medicare/Medicaid cost report. Ten percent of each of these cost per discharge amounts will be added on to the base rate.

Pediatric Specialty Hospitals will receive an additional adjustment factor of 1.322 to account for the specialty care provided. ~~This adjustment factor will not be applied to~~ the Medicaid cost add-ons.

For PPS Rehabilitation and Specialty-Acute Hospitals, the hospital specific Medicaid base rate will be the Medicare TEFRA rate from the most recently audited Medicare/Medicaid cost report (CMS 2552) divided by the Medicaid case mix index and then modified by a set percentage equally for all PPS Rehabilitation and Specialty-Acute Hospitals. The percentage will be the percentage used to modify the Medicare base rate of all other PPS hospitals multiplied by 1.560. The Medicare/Medicaid cost report and Medicaid case mix index used for this calculation will be those available as of March 1 each year.

Beginning July 1, 2004, acute rehabilitation centers that specialize in spinal cord and traumatic brain injuries shall receive an additional adjustment factor of 1.000 to account for the specialty care provided.

Beginning July 1, 2004 Urban Center Safety Net Specialty Hospitals shall receive an additional adjustment factor of 1.0895 to account for the specialty care provided. To qualify as an Urban Center Safety Net Specialty Hospital, the urban hospital's Medicaid days plus Colorado Indigent Care Program (CICP) days relative to total days, rounded to the nearest percent, shall be equal to or exceed sixty-seven percent. Medicaid and total days shall be Medicaid eligible inpatient days and total inpatient days from the most recent survey requested by the Department prior to March 1 of each year for July 1 rates. If the provider fails to report the requested days, the days used shall be collected from data published by the Colorado Hospital Association in its most recent annual report available on March 1 of each year. The CICP days shall be those reported in the most recently available CICP Annual Report as of March 1 of each year.

Hospital specific Medicaid base rates are adjusted annually (rebased) and are effective each July 1. Medicaid base rates will be made consistent with the level of funds established and amended by the General Assembly, which is published in the Long Bill and subsequent amendments each year. Any changes to the rate setting methodology will be approved by the Medical Services Board and the Centers for Medicare and Medicaid Services prior to implementation. Once funds and rate setting methodology have been established, rate letters will be distributed to providers qualified to receive the payment each fiscal year and 60 days prior to any adjustment in the payment. Rate letters will document the Medicaid base rate and other relevant figures for the specific provider so that providers may understand and independently calculate their payment. Rate letters allow providers to dispute the payment on the

basis that payment was not calculated correctly given the established funds and rate setting methodology.

9. Exempt hospitals are those hospitals which are designated by the Department to be exempt from the DRG-based prospective payment system. The Department may designate facilities as exempt or non-exempt providers. Non-exempt providers shall be reimbursed using the DRG-based prospective payment system (PPS). Exempt hospitals will be paid a per diem for inpatient hospital services. As of July 1, 2003 free-standing psychiatric facilities shall be the only exempt providers.